View metadata, citation and similar papers at core.ac.uk

brought to you by CORE

provided by British Columbia's network of post-secondary digital repositories

"I WANT TO LEARN MORE": PROFESIONALS' PERSPECTIVES REGARDING TRAINING AND SUPPORT NEEDS FOR METHADONE MAINTENANCE USERS IN TREATMENT

by

Justun Miller
Bachelor of Social Work, University of the Fraser Valley 2010

MAJOR PAPER SUBMITTED IN PARTIAL
FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SOCIAL WORK

In the
School of Social Work and Human Services

© Justun Miller, 2014

UNIVERSITY OF THE FRASER VALLEY

Spring 2014

All rights reserved. This work may not be
reproduced in whole or in part, by photocopy
or other means, without permission of the author.

Approval

Name: Justun Miller

Degree: Master of Social Work

Title of Thesis: "I want to learn more": Professionals' perspectives regarding training and support needs for methadone maintenance users in treatment

Examining Committee:

Chair:

John Hogg, BA, BSW, MSW, RSW
Faculty, School of Social Work and Human Services

Leah Douglas, BSW, MSW, PhD, RSW
Senior Supervisor
Faculty, School of Social Work and Human Services

Lisa Moy, BA, BSW, MSW, PhD, RSW
Supervisor
Faculty, School of Social Work and Human Services

Date Defended/Approved: April 11, 2014

The author, whose copyright is declared on the title page of this work, has granted to the University of the Fraser Valley the right to lend this major paper, thesis, project or extended essay to users of the University of the Fraser Valley Library, and to make partial or single copies only for such users or in response to a request from the library of any other university, or other educational institution, on its own behalf or for one of its users.

The author has further granted permission to the University of the Fraser Valley to keep or make a digital copy for use in its circulating collection, and, without changing the content, to translate the major paper/thesis/project or extended essay, if technically possible, to any medium or format for the purpose or preservation of the digital work.

The author has further agreed that permission for multiple copying of this work for scholarly purposes may be granted by either the author or the Associate Vice-President, Research and Graduate Studies.

It is understood that copying or publication of this work for financial gain shall not be allowed without the author's written permission.

Permission for public performance, or limited permission for private scholarly use, of any multimedia materials forming part of this work, may have been granted by the author. This information may be found on the separately catalogued multimedia material and in the signed Partial Copyright Licence.

The original Partial Copyright Licence attesting to these terms, and signed by this author, may be found in the original bound copy of this work, retained by the University of the Fraser Valley Heritage Collection.

University of the Fraser Valley
Abbotsford, B.C.

University of the Fraser Valley
Partial Copyright License

I hereby grant the University of the Fraser Valley the right to lend my major paper / thesis / project / extended essay to users of the University of the Fraser Valley Library or to other libraries. Furthermore, I grant the University of the Fraser Valley Library the right to make single copies only of my major paper / thesis / project / extended essay for users of the library or in response to a request from other libraries, on their behalf or for one of their users.

I further grant permission to the University of the Fraser Valley to keep or make a digital copy for use in its library collection and / or institutional repository.

Permission for extensive copying of this major paper / thesis / project / extended essay may be granted by me or by a member of the University designated by me.

It is understood that copying or publication of this major paper / thesis / project / extended essay for financial gain shall not be allowed without my written permission.

Permission for public performance, or limited permission for private scholarly use, or any multimedia materials forming part of this work, is covered by a separate agreement if applicable.

Title of major paper / thesis / project / extended essay:

"I want to learn more": Professionals' perspectives regarding training and support needs for methadone maintenance users in treatment

Author (print name): Justun Miller

Signature:

Date:

Abstract

The purpose of this research was to gather and analyze the perceptions of professionals who work in residential and outpatient substance use treatment organizations about the effectiveness of Methadone Maintenance Treatment (MMT) within their substance use treatment settings. This research provides a current understanding of the perceptions, experiences, observations, insights, and beliefs of professionals working directly with MMT using clients within residential and outpatient substance use treatment organizations. Qualitative information was gathered through individual face-to-face interviews, using a cross-sectional exploratory design (Dudley, 2011), and following a general interview guide approach. A qualitative analysis of the data was performed using the theme analysis method (Dudley, 2011; Grinnell et al, 2010). The findings of the research show a need and desire for education, training, and support specific to working with the MMT using population. Implications of the research are that the findings can be used towards developing and/or implementing best practices by influencing existing training and support structures to better meet the needs of professionals working with the MMT using population.

Keywords: Addiction, Harm Reduction, Marginalization, Methadone, MMT, Stigmatization, Substance Use

Acknowledgements

I cannot express enough thanks to the UFV faculty and my MSW cohort for their continued support and encouragement. In particular, I would like to acknowledge Dr. Adrienne Chan, and Dr. Leah Douglas. You have both been and continue to be truly inspirational to me and your guidance and support throughout my educational journey have been invaluable.

I would also like to express my appreciation to those who so generously shared their time and participated in the research by sharing their stories, knowledge, and experience. This project would not have been possible without their invaluable contributions.

Dedication

This paper is dedicated to my beautiful, caring, and loving wife, Erin: Thank you for your unfailing love, support, and motivation throughout this most incredible ride. I could not have done this without you.

Table of Contents

Introduction

Dependence on opiates is a serious, chronic condition that has significant medical, social, and economic implications for individuals and society. Methadone is a synthetic opiate that occupies the brains receptor sites affected by heroin and other opiates (CAMH, 2009). Methadone Maintenance Treatment (MMT) is an approach internationally recognized as being one of the most effective for treating opiate addiction when utilized as part of holistic intraprofessional treatment practices (CAMH, 2009; CAMH, 2011; Gu, Xu, Lau, Hao, Zong, Fan, Zhao, Hao & Lin, 2012; Maremmani, Pacini & Pani, 2011; Martin, Lewis, Josiah-Martin & Sinnot, 2010; Parks & Reist, 2010; Wackerhausen, 2009).

Methadone Maintenance Treatment

Fraser Health accredited residential and outpatient substance use treatment organizations are required to accept clients using MMT despite the incongruence of this treatment modality with some organizations abstinence-based theoretical foundations. This incongruence leads to a lack of consistency in service provision and inter-client experiences (Fraser Health, 2011; Goheen, 2013). Minimal literature exists on the effects of service provider perceptions of MMT effectiveness and acceptability within residential and outpatient substance use treatment organizations. This incongruence is rooted in differing understandings of the purpose, effectiveness, and best practices of MMT delivery by those providing clinical services to the MMT using population (Goheen, 2013; Gu et al, 2012, Mitchel et al, 2006). Using anti-oppressive and harm reduction theoretical frameworks, this knowledge gap is addressed in this research.

It is not uncommon for MMT using clients to experience stigmatization from those providing them with services, as a result of a belief that clients using MMT are not “clean”, or

that they are morally flawed. These beliefs and perceptions can also lead to MMT using clients experiencing marginalization and exclusion from certain recovery communities (Goheen, 2013; Gu et al, 2012; Mitchel, Dyer, & Peay, 2006). This stigmatization and marginalization, in addition to the variability in perceptions, approaches, and practice to MMT delivery between service providers, has been shown to lead to reluctance to access services, increases in dropout rates, and a general decrease in treatment retention and positive outcomes experienced by those that do access services (Goheen, 2013; Gu et al, 2012; Mitchel et al, 2006).

As a Registered Social Worker (RSW) working in the role of Drug and Alcohol Counselor within a Fraser Health Authority contracted agency, the writer has observed knowledge and service gaps in this area. The writer has also participated in contract work with the Fraser Health Authority in which he conducted interviews for a survey of consumer, treatment cohort and substance use service professional's perspectives on MMT which further highlighted the knowledge and service gaps surrounding the provision of services to MMT using clients (Goheen, 2013).

The intent of this research is to collect and analyze the perceptions of professionals working within residential and outpatient substance use treatment organizations about their perceptions of the effectiveness of MMT for clients within their substance use treatment settings. The research will provide a current understanding of the perceptions, experiences, observations, insights, and beliefs of professionals working directly with MMT using clients within residential and outpatient substance use treatment organizations. The study will identify perceptions that positively and negatively impact the provision of services to MMT using clients. An additional aim of the research is to identify existing training and supports available to professionals

working with the MMT using population, to identify if further MMT specific training, supports, and services are needed and/or wanted.

Literature Review

For the purposes of this literary review the researcher has chosen to use peer reviewed journal articles retrieved from the UFV library. Key words used when searching for the journal articles were: methadone maintenance; harm reduction; addictions treatment; professional; service provider; perceptions; and stigma. Included articles were peer reviewed, not dated earlier than 2005, and, where possible contained the perspectives of professionals working with clients using MMT. It soon became very apparent to the researcher that there is a gap in the literature in regards to perceptions, experiences, observations, insights, and beliefs of the professionals providing substance use treatment to those using MMT in substance use treatment settings, and what supports and education they require, if any, to better serve and support this population. However, a significant amount of literature does exist on the perceptions, experiences, observations, insights, and beliefs of service recipients (Chen et al, 2009; Lee & Zerai, 2010; Little & Franskoviak, 2010; Smye et al, 2011). The themes drawn from the literature were as follows: the juxtaposition of abstinence and harm reduction frameworks; the value of therapeutic relationships in working with clients using MMT; the effects of stigma towards drug users; and the providers of treatment.

The research shows that MMT is an effective harm reduction treatment and reduces the harms experienced by clients experiencing opioid dependence, and that the establishment and maintenance of strong therapeutic relationships between professionals delivering substance use treatment services and those using MMT are significant predictors of positive client outcomes

(CAMH, 2009; CAMH, 2011; Gu et al, 2012; Health Canada, 2008; Maremmani et al, 2011; Martin et al, 2010; Parks & Reist, 2010).

Abstinence and Harm Reduction Frameworks

In the early 1900's the treatment of opiate addiction was addressed with the use of morphine in physician's offices. As opiate dependence increased, behavioral abstinence based approaches were adopted with little to no success. Methadone was first developed in Germany during the Second World War as an analgesic, and further research conducted in the United Kingdom identified methadone's properties as an effective heroin withdrawal management treatment (CAMH, 2011). In the 1950's and 1960's when opioid use became a significant issue resulting in substantial increases in crime and death, further research on methadone showed that it is effective in preventing withdrawal symptoms, blocking heroin euphoria, and decreasing cravings (CAMH, 2011).

In the 1960's Canadian researcher Dr. Robert Halliday of Vancouver, British Columbia was the first person in the world to implement a MMT program. MMT is a harm reduction approach to opioid dependence treatment, which through substitution for opioid use and as a part of a holistic ongoing client-centered, collaborative, inter/intradisciplinary approach to treatment can support clients to attain stable levels of psychological, physiological, and social functioning through either long term/life long or eventual discontinuation of MMT (CAMH, 2011; Wackerhausen, 2009).

Despite the lack of centralized registries in all provinces for MMT using patients which prevents accurate reports of MMT using clients, there is a general consensus that the demand for access to MMT services is increasing dramatically across Canada. Two of the most significant increases in MMT utilization recorded are in British Columbia and Ontario where numbers have

increased from 2,827 in 1996 to 11,033 in 2009, and 700 in 1996 to 29,743 in 2010 respectively (Luce & Strike, 2011). It is estimated that there are over 80,000 illicit opioid users in Canada and approximately 50,000 MMT users (CAMH, 2011; Luce & Strike, 2011). The present context within which MMT using clients receive services is very diverse and continues to change as service providers adapt to its inclusion in their organizations. Clients using MMT are now present in correctional, residential, and outpatient programming that can include one-on-one and group counseling (Chen, Masson, Sorensen & Greenberg, 2009; Goheen, 2013; Luce & Strike, 2011). It has been shown in the literature that a significant contributing factor to the diversity in the provision of MMT services is due to the influences of personal subjectivity on behalf of the prescribing physicians and non-medical factors such as housing, and socioeconomic status (Goheen, 2013; Gu et al, 2012; Mitchel et al, 2006). The literature shows that varying daily dosages of methadone are the most effective in supporting clients to abstain from opioid use with clinical practice guidelines recommending a minimum dosage of between 10 - 30 milligrams (mg) a day depending on individual risk factors of methadone toxicity (CAMH, 2011). It is also acknowledged within the literature that effective dosages of methadone can vary from 60 mg - 100 mg depending on the biopsychosocial-spiritual factors in the individual clients lives, such as age, health, and living situation, to mention a few, and that determining appropriate dosages is an inherently fluid and subjective process which is best achieved collaboratively between the prescribing physician, client, and their supports in order to address each client's unique needs (Trafton, Minkel & Humphreys, 2006; CAMH, 2011).

Harm reduction is an approach to substance use treatment which centers around increasing the safety of substance users and minimizing associated disease, injury, and death through initiatives such as MMT, needle exchange programs, condom distribution, and supervised

injection sites to name only a few (CAMH, 2011). Harm reduction practices simultaneously decrease experiences of stigmatization and marginalization for substance users by working with them at a level they are comfortable with and supporting them to make informed decisions which will work the best for them and their unique life situations (CAMH, 2013). As such, harm reduction is a holistic approach that can lead to the achievement of a greater quality of life for individuals using substances through safer drug use practices and even abstinence (Health Canada, 2008).

There is significant evidence that harm reduction practices such as MMT are effective in decreasing the harms associated with substance use (CAMH, 2013; Baines, 2011; Ball, 2007; Kerr et al, 2006). Charitable organizations dating as far back as the Victorian era have been providing individuals with substance use issues with clothing and food (Baines, 2011). Present day programs designed to reduce the harm experienced by individuals using substances continue in the form of practices/programs such as MMT, condom distribution, supervised injection sites, and needle exchange. MMT has been used successfully in Vancouver, British Columbia as an extended withdrawal program since 1962 (CAMH, 2003). Despite such an ongoing commitment to reducing the harms to individuals and a significant body of evidence to show the approaches effectiveness, the substance use field remains divided on the topic (CAMH, 2013; Baines, 2011; Ball, 2007; Kerr et al, 2006).

The predominant theoretical perspective/knowledge base in regards to addiction in western society is best represented by Alcoholics Anonymous and other conventional abstinence-only forms of drug treatment, from this point on referred to as abstinence-only programs (CAMH, 2003; Gowan, Whetstone & Andic, 2012; Kerr, Small, Peeace, Douglas, Pierre, Wood, 2006). Abstinence-only programs view alcoholism through a medical model lens (Baines, 2011;

CAMH, 2003) that defines addiction as a disease that individuals are powerless over and for which the only "cure" is to acknowledge powerlessness over the disease and abstain completely from use. Essentializing substance users into a homogenous group not only reinforces and perpetuates societal perceptions of substance users as immoral, deviant, and undeserving, but also individualizes the issue which reinforces and perpetuates marginalization and stigmatization. The medical model does not acknowledge biopsychosocial, sociopolitical, cultural, historical, or any other context in which substance use occurs. Failure to acknowledge the contextual factors in clients' lives listed above when combined with societal and self-marginalization can lead to substance users viewing abstinence-only programs as barriers to accessing services (Gowan et al, 2012; Lee & Zerai, 2010; Sellman, 2009; Smye et al, 2011).

Abstinence-only programs do however prove to be effective for some substance users. Longitudinal studies have shown that up to one third of people receiving treatment through abstinence-only programs achieve abstinence following successful completion of treatment. Yet, studies go on to show that this abstinence is not sustainable, and that only ten percent maintain long-term abstinence (Sellman, 2009). Despite the potentially negative and oppressive features of abstinence-only programs, in comparison to more client-centered models such as cognitive behavioral therapy, research has shown that there is little to no difference in outcomes based on the therapeutic style used, and that it is primarily the therapeutic relationship that is the most influential factor, and that these relationships are better established through a low barrier approach to service delivery such as harm reduction (Cooper & Lesser, 2011; Kahn, 1991; Sellman, 2009).

Therapeutic Relationships

The literature shows that developing a strong therapeutic relationship and working alliance with clients is essential if positive client outcomes and harm reductions are to be achieved (CAMH, 2003; Cooper & Lesser, 2011; Little & Franskoviak, 2010; Blume & Lovato, 2010). A strong therapeutic relationship is one in which there is mutual trust between the client and the worker, and the client is an active participant in the relationship. This means that clients work collaboratively with workers to identify issues and goals, and together they determine how best to address them, and in what order (Blume & Lovato, 2010; Lee & Zerai, 2010; Rollnick & Miller, 2009).

The literature shows that in order for therapeutic relationships to be effective, workers must adopt an approach towards clients which is curious and "not knowing" (Cooper & Lesser, 2011; Little & Franskoviak, 2010). This approach sets the collaborative tone for the relationship and further shows the client that the worker is not there to tell them what to do, but more to work collaboratively with them in achieving their goals. Harm reduction approaches depend on the workers' abilities to work respectfully, reciprocally, responsively, collaboratively, and genuinely with clients to form working relationships (Congress, 2008; Cooper & Lesser, 2011; Dalton, 2005; Kahn, 1991; McNamee & Gergen, 2010). Through these working relationships, workers are able to assist clients to recognize themes in their lives, or become aware of perceptions that they would otherwise have been unaware. This approach to practice helps clients and practitioners to see their situations from a different perspective, and as such, become aware of more effective ways to address them (McNamee & Gergen, 2010). The strength of harm reduction strategies, such as MMT, lies in their ability to be able to balance the pros and cons for individuals, as well as society, and promote initiatives that are beneficial for the individual and

the common good such as continuing to use drugs intravenously, but to do so with clean needles thus reducing health care costs as a result of blood borne infections (Baines, 2011; CAMH, 2003; Pauly, 2008; Karger & Hernandez, 2004; Kerr et al, 2006).

Stigma Towards Drug Users

The effects of stigma and marginalization on individuals experiencing substance misuse issues have been extensively researched and studied, and the research states that experiences of marginalization by substance users are associated with an unwillingness to access and/or continue services (CAMH, 2003; Gu et al, 2012; Little & Franskoviak, 2010; Smye et al, 2011). Many studies on harm reduction have identified that providing low barrier services which include harm reduction practices such as MMT, condom distribution, and needle exchange, increase the exposure of those misusing substances to available services, therefore increasing their access to services (Baines, 2011; CAMH, 2003; Gowan et al, 2012; Kleinig, 2008; Lee & Zerai, 2010; Sellman, 2009; Smye et al, 2011).

Research on the factors affecting substance misusers' decisions to access services continues to grow, and the lack of harm reduction practices has been identified as a significant barrier (Little & Franskoviak, 2010; Smye et al, 2011; Gu et al, 2012). There is limited research on the effectiveness and integration of harm reduction techniques such as MMT within substance use treatment settings, and whether or not service providers require additional training and supports to provide this population with effective services (Chen et al, 2009; CAMH, 2003).

A major theme in the existing literature on MMT is that it is a very effective form of treatment for reducing the harms experienced by illicit opiate use. The benefits and harm reductions of MMT include improved social functioning, improved program engagement, improved therapeutic relationships leading to more positive treatment outcomes and retention of

knowledge, and overall greater client satisfaction. MMT has also been shown to decrease criminality, decrease transmission of blood borne infections such as hepatitis B, C, and HIV due to the omission of needle use, and decrease experiences of stigmatization (Bennett, 2011; Carlin, 2005; CAMH, 2003; Go, Dykeman, Santos & Muxlow, 2011; Kelly, O'Grady, Brown, Mitchell & Schwartz, 2010).

Who Provides Treatment?

Literature shows that the provision of MMT is most effective when utilized as part of a holistic approach which includes: specific supports for MMT clients; multidisciplinary teams, family, and community involvement so that the situation is not individualized; and holistic initiatives and supports that are used to collaboratively work towards sustainable change (Gu et al, 2012; Martin et al, 2010; Goheen, 2013). Treatment for MMT using clients is provided by a very diverse spectrum of professionals which can include, but is not limited to doctors, nurses, pharmacists, social workers, counselors, and support staff.

Doctors receive specific training in MMT, but research still shows that personal subjectivity related to personal beliefs can play a role in MMT prescription (Mitchel et al, 2006). This, combined with myths held by MMT using individuals and service delivery professionals, can increase experiences of stigmatization and marginalization. This in turn can increase client dropout rates, and contribute to decreases in the retention and positive outcomes experienced by those that do access services (CAMH, 2003; Goheen, 2013; Gu et al, 2012). Understanding and addressing the diverse perceptions of those providing services to the MMT using population is essential in identifying the origins of stigmatizing/marginalizing beliefs, and to increase the consistency of services received between organizations (Goheen, 2013; Gu et al, 2012; Chen et al, 2009). Understanding and incorporating the diverse expertise and knowledge base of those

working with clients using MMT ensures that MMT is not utilized as a standalone initiative, and that it is used as part of a collaborative multidisciplinary practice delivered by educated team members (CAMH, 2003).

Gaps in Literature

Despite the more than thirty years of research conducted on the effectiveness of MMT, and its endorsement by international researchers and professionals as 'the gold standard for treatment programs designed to treat opioid dependent individuals' (Go et al, 2011.p.18), it is still not accepted by all substance use treatment service providers (CAMH, 2003; Carlin, 2005; City of Abbotsford, 2013; Philbin & Zhang, 2010; Goheen, 2013).

There is in fact a significant lack of research in regards to understanding the perceptions and needs for specific training and supports for those other than physicians and nurses (Mitchel et al, 2006; Strang, Hunt, Gerada & Marsden, 2007) providing services to clients using MMT. Understanding the perceptions of clinical service providers may provide a way in which to address the potentially stigmatizing and marginalizing practices utilized by some professionals whose practices are based on skepticism and myths surrounding the use/effectiveness of MMT in substance use treatment settings (Gu et al, 2012).

Research Problem

The purpose of this research is to examine the perceptions of professionals who work with clients using MMT in regards to the effectiveness of MMT within residential and outpatient substance use treatment organizations. The research question is: What are the perceptions of professionals who work with MMT clients with regards to whether or not MMT use is effective in substance use treatment settings? The objectives of the research are:

1. To explore the perceptions of professionals in regards to the effectiveness of MMT in substance use treatment settings.

2. To determine if a need exists in regards to training for professionals in substance use treatment settings around working with clients using MMT.

3. To determine if a need exists in regards to support for professionals in substance use treatment settings around working with clients using MMT.

The research question and research objectives are intended to focus on exploring the perceptions, experiences, observations, insights, and beliefs of professionals working with the MMT using population, and determine the needs of participants with respect to knowledge, training, and support for working with this population**.**

Theoretical Framework

Harm Reduction

Focusing exclusively on reducing the harms experienced by individuals with substance use issues by prescribing methadone without the support of other services is a "band-aid" fix (Baines, 2011.p. 8). This band-aid fix at best ignores larger societal problems which contribute to substance use, and at its worst attempts to hide them beneath individual deficits and poor decision making (Bains, 2011; Raphael, 2007). Medical model approaches also focus on how to cure the individual rather than how to take a preventative stance and address the larger societal contributing factors to the issue of substance use (Baines, 2011; CAMH, 2003; Kleinig, 2008; Lee & Zerai, 2010; Raphael, 2007; Smye, Browne, Varcoe & Josewski, 2011). MMT has been utilized to support those struggling with opiate dependence since as early as 1963 (CAMH, 2011), and is an evidence-based practice which has been scientifically shown to be an effective harm reduction initiative. There is still division within the substance use treatment field as to the appropriateness of clients using MMT while accessing substance use treatment because of

strongly held perceptions that individuals using methadone are still using drugs. This division can lead to those choosing to use MMT while seeking treatment and support to experience marginalization and discrimination from the very ones they are turning to for support (Bennett, 2011; CAMH, 2003; Carlin, 2005; City of Abbotsford, 2013; Go et al, 2011; Kelly et al, 2010; Philbin & Zhang, 2010).

Harm reduction is most effective when it incorporates anti-oppressive practices by engaging in work to de-marginalize and de-stigmatize clients (Baines, 2011; CAMH, 2003; Kerr et al, 2006; Osborn & Small, 2005; Pauly, 2008; Smye et al, 2011). Anti-oppressive practice is an approach that assists clients, communities, and workers to understand the sources of oppression in their lives and works towards changing them on micro, mezzo, and macro levels (CAMH, 2003; Baines, 2011). As such, the research conducted was done with the intention of gathering the perceptions of those providing services to this stigmatized and marginalized population. It is intended that when these perceptions are analyzed a greater understanding can be attained as to whether or not a need exists for the provision of specific training and/or supports to service providers working with MMT using clients in substance use service settings. This understanding can be used to decrease and address the perpetuation of clients' experiences of stigma, marginalization, and oppression (Goheen, 2013; Gu et al, 2012, Mitchel et al, 2006).

Design and Methodology

Method and Design

This study used a cross-sectional exploratory design (Dudley, 2011). Qualitative information was collected through open-ended face-to-face interviews using a general interview guide approach (see Appendix D). The focus of the questions was the perceptions, experiences, observations, insights, and beliefs of the participants, with respect to MMT. Approval was

granted by the Human Research Ethics Board at the University of the Fraser Valley (see Appendix A).

Recruiting Process/Sample

A criterion/purposive sampling method was used to optimally recruit six to ten participants, who were drawn from a range of professional service providers employed by organizations that have direct contact in one-on-one and/or group settings with clients using MMT. The recruitment process for this project proved to be very challenging. The researcher had no relationship with the organizations being contacted and engaged in 'cold calling' in an attempt to recruit potential participants. Initially the sample being sought was professionals working in residential treatment centres who work with clients using MMT. Six Fraser Health accredited residential treatment centres were contacted by phone and e-mail (see Appendix B). Fraser Health accreditation is a process through which internal agency assessments are conducted every three years in order to identify program/agency strengths and areas for improvement. External assessments are also conducted to validate the quality of the care being provided (Fraser Health, 2011). Following significant follow-up work through phone conversations and e-mail correspondence, only one of the six residential treatment centres agreed to participate in the research.

Several factors were identified by the agencies contacted as contributing to their reluctance/inability to participate, including, but not limited to: staffing shortages; inability to accommodate the time required to participate in the interviews; and the belief that the research was not of significance to their agency. Due to the fact that only five participants had been recruited, the researcher submitted an amendment to the UFV Human Research Ethics Board so that a potentially larger sample could be attained by broadening the sampling criteria to include

professionals who work with clients using MMT in outpatient substance use treatment settings. Following this amendment, the researcher was able to implement the same recruiting procedures as identified above and schedule additional participants, increasing the sample size to eight.

Data Collection

A letter of informed consent was signed prior to the start of the interviews (see Appendix C). Interviews were conducted with interested individuals at their place of employment in counselor's offices and/or group session rooms so as to ensure confidentiality. Interviews took approximately one and a half hours to complete, and participants were asked to give permission to record their interviews in both audio and hand written formats. Basic demographic information was gathered throughout the meeting, and this information was used to contribute to theme analysis. For each interview, hand-written notes were taken with full knowledge and consent of each participant. When permitted, interviews were audio-recorded to increase the accuracy in reporting and summary of the information, all participants agreed to have their interviews audio-recorded. The researcher reviewed the interpretations of answers with participants following the interview to check for accuracy and allow for clarification or additional comments (Dudley, 2011; Grinnell et al, 2010). This practice proved to be effective and significant in that participants were able to provide clarifications and expansions on their initial responses.

The information collected through the interviews focused on questions about the perceptions, experiences, observations, insights, and beliefs of the participants as they relate to the effectiveness of MMT in substance use settings (Dudley, 2011). These questions support the research objectives which focus on exploring perceptions and determining the needs of participants with respect to knowledge and training.

Data Analysis

Following the interviews the researcher transferred the hand-written interview data to a Microsoft Word document the same day they were conducted for accuracy, ease of use, storage, and confidentiality purposes. Each interview was recorded in a separate document and coded according to participant name and employing agency. A hard copy of the research question and objectives were printed off of the researcher's computer and kept in front of him while the data was reviewed several times by reading the documents and listening to the recorded interviews. This was done in order to familiarize the researcher with the material and ascertain the relevance of the data collected to the research question (Dudley, 2011; Grinnell et al, 2010). Continued periodic revision of data was conducted in order to ensure that identified themes remained salient (Grinnell et al, 2010).

Once a sufficient level of familiarity with the data was attained, a qualitative analysis of the data was performed using the theme analysis method (Dudley, 2011; Grinnell et al, 2010). The focus of the analysis was on how each individual participant responded to each question in the interview, and what themes and variances could be identified. The process of identifying themes was multidimensional in that the objectives of the research were initially used as preset categories. This level of analysis allowed the researcher to determine the degree to which the data collected answered the research question and objectives. It also allowed for the identification of an additional larger theme not previously identified. Categorized information was highlighted and color-coded in the documents. The categorized information was further analyzed through repeated revisions leading to the identification of emergent subcategories/themes within the four larger initial categories which were coded (Dudley, 2011; Grinnell et al, 2010).

Ethical Approval

Ethical approval was applied for and granted through the University of the Fraser Valley Human Research Ethics Board (see Appendix A). There were no anticipated risks for participation in the research, and the researcher minimized the risk to participants by ensuring that the data collection process took place in rooms which ensured confidentiality. Additionally, no names or identifying information was used in the final report in order to maintain anonymity. Confidentiality concerns were raised by participants prior to the interviews commencing. Participants were referred to the informed consent form and reassured that no identifying personal or agency information would be used in the final report, and that this raw information would only be accessible to the researcher and his supervisors. Respect, responsibility, relevance and reciprocity were prominent ethical considerations for this research due to the focus on telling others' stories (Adichie, 2009; Chan, 2013; Heron, 2005). Outside of these initial concerns for confidentiality there were no other concerns expressed by the participants.

Ethical Approval Process

Signed letters of informed consent (see Appendix C) were stored at the researcher's secured place of work. The forms were secured in a locked filing cabinet in the researcher's locked office. The audio files were saved on the researcher's password secured computer also located in his locked office. The physical, audio, and electronic data collected will be deleted upon the successful completion of the researcher's major paper, and no later than February 4, 2014 as per the UFV Human Research Ethics Board Approval documentation. Physical written files will be disposed of through a secure paper shredding company utilized by the researcher's organization. Audio files were deleted from the recording device used for the interviews once transferred to the researcher's secure computer. These files will be deleted upon the successful

completion of the researcher's major paper and no later than the above specified date for the physical files.

Measures were taken to ensure that the researcher took on the responsibility to ensure that the information produced by the research was an honest and accurate understanding, interpretation and representation of the perceptions, experiences, observations, insights, and beliefs of the participants. This concern was addressed by incorporating collaborative practices which provided the opportunity for participants to read and discuss the information collected during their interview, and by the researcher engaging in critical self-reflection, and raising self-awareness of any possible assumptions or biases that may have been present. A copy of the final report will also be provided to the organizations that participated. This process ensured that the participants and their contributions were respected, and also that a high level of transparency was maintained.

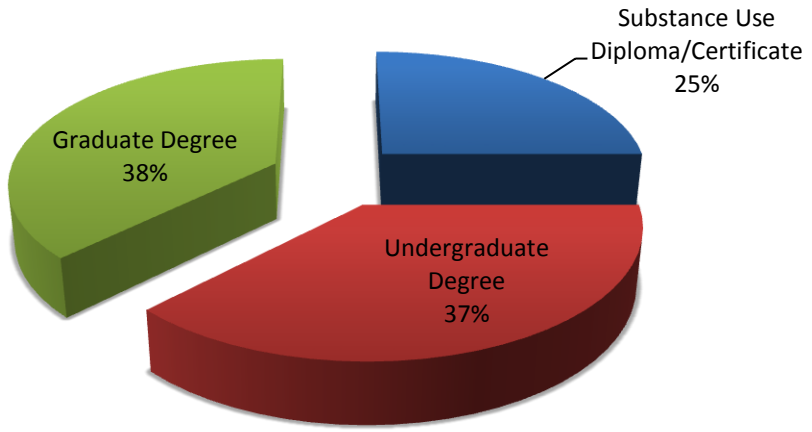
Findings

The organizations/agencies from which the eight participants were drawn adhere to an eclectic framework consisting of Alcoholics Anonymous (AA), bio-psycho-social-spiritual, client-centered, and harm reduction approaches to practice. The participants all have post-secondary education including, but not limited to, Substance Use Diplomas, Counseling/Social Work Undergraduate and Graduate Degrees, and combinations thereof.

In order to be able to achieve the research objectives the researcher collected demographic information on the participants. This information was gathered in order to be able to gain a deeper understanding of the professional population providing services to clients using MMT. The literature review conducted above showed that there is a dearth of training and supports for professionals other than physicians and nurses (Gu et al, 2012; Mitchel et al, 2006; Martin et al,

2010; Goheen, 2013). Information about gender, age, ethnicity, level of education, year education was achieved, years working in the substance use field, position/classification, and model/s of recovery used at the organization was collected in order to determine who is providing services to the MMT using population. Information was also collected to ascertain the existing training and supports that are being provided to meet the needs of the professionals working closely with the MMT using population. The background information of the research participants revealed the following characteristics as displayed in Figure 1:

Figure 1: Present Education Level of Participants



Twenty-five percent of participants had achieved Substance Use Diplomas/Certificates as their highest level of education. Out of this twenty-five percent, 50% percent identified that they were either enrolled or planning to enrol in undergraduate programming. Thirty-seven percent of participants had attained Undergraduate Degrees as their highest level of education, with 33% of these participants currently enrolled in Graduate Degree programs. Thirty-eight percent of the participants possessed Graduate Degrees as their highest level of education. This information

reflects the significant level of commitment within the sample to the importance of higher education. The age of the participants in the sample ranged from 34 to 59 years of age, with the average age of participants being 45 years old. Twenty-five percent of the participants were female, and 75% were male. When asked by the researcher to identify their ethnicity, twelve-and-a-half percent of the participants identified as Metis, with the remaining 87.5% identifying as Caucasian. The job classifications of those interviewed ranged from Program Support Workers, to Clinical Managers. The number of years worked in the substance use field by the participants ranged from four years to fifteen with the average years worked in the substance use field for the sample being seven.

Interpretation of Results

The following categories/themes were identified within the data collected: positive professional perceptions of MMT; invisibility of MMT clients' needs; desire for training in MMT specific practices; and desire for collaborative practices/supports.

Positive Professional Perceptions of MMT

Participants unanimously identified that the use of MMT significantly reduces barriers for clients struggling with opiate use issues to access residential and outpatient substance use services. It was also identified that the use of MMT assists clients to attain the levels of mental and physical stability which are required to access these services. One participant's statement reflected these sentiments succinctly when he stated that "Methadone maintenance therapy increases the client's access to supports which would otherwise not be available to them due to cravings, behaviours, and perceptions". Participants also looked favourably upon MMT's significant harm reduction benefits, such as decreases in criminality; and decreased transmission of blood borne infections such as hepatitis B, C, and HIV due to the omission of needle use

(Health Canada, 2008).

Participants all perceived MMT as a positive practice and supported its use in substance use treatment settings due to beliefs that its use increases clients' ability to be able to retain psychoeducational material through improved engagement in groups and one-on-one sessions. This was an interesting theme due to the diverse personal frames of references of the participants which ranged from the endorsement of abstinence-based practices to harm reduction ideological standpoints.

Dosage

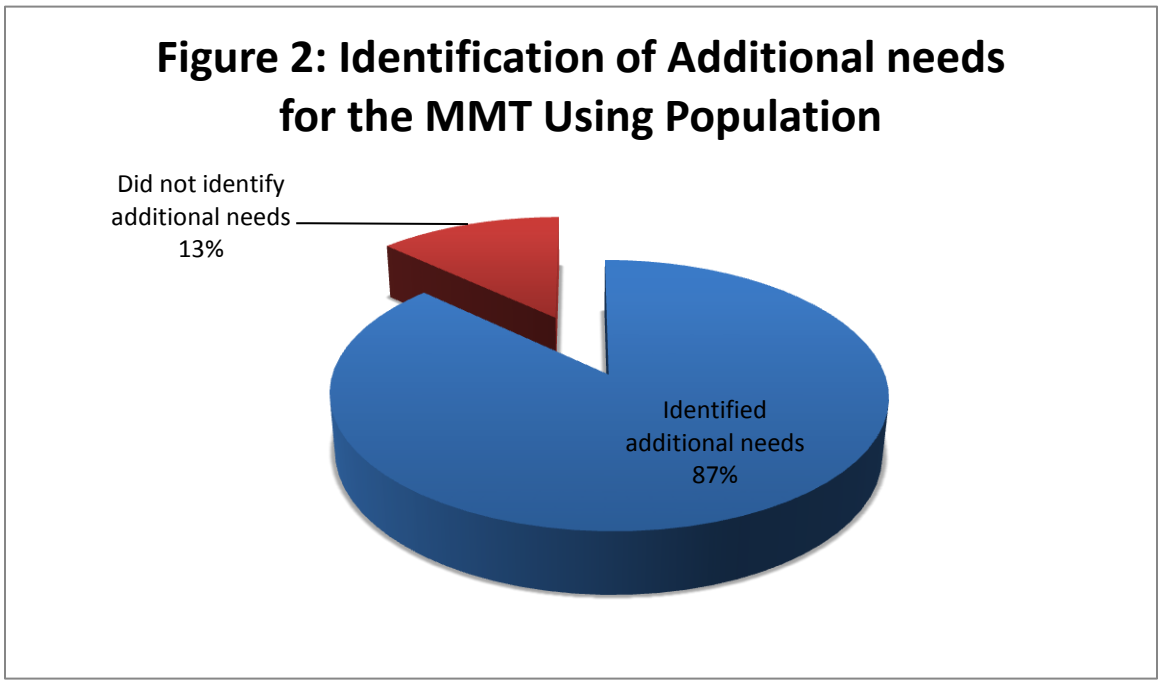
Participants' perspectives in regards to MMT's effectiveness were dependent upon the effects of the methadone dosages on the individual clients. Clients receiving "appropriate" dosages of methadone so that they are alert during groups and sessions and not "nodding" were positively perceived by the group members and facilitators. It was identified by participants that clients who were over-medicated were not looked upon favourably due to perceptions by group members that they are "not participating", "still using" and that their behaviors are "triggering" to other group members. Conversely, clients who were under-medicated were seen to be experiencing withdrawal symptoms and again were perceived as not participating and were triggering to other group members. The challenges experienced by professionals in effectively managing these situations were exacerbated given the diverse nature of the groups' participants, time limitations, and lack of ability to address these clients' individual needs.

Discussion surrounding MMT dosage uncovered a very diverse range of responses and perspectives in regards to whether or not clients should be maintaining a consistent MMT dosage while accessing services or should be adjusting their dose during this period. This also led to the identification of diverse beliefs amongst participants in regards to whether or not MMT is a short

or long-term treatment. It was identified that clients adjusting MMT dosages while accessing treatment services were less participatory during one-on-one sessions and groups as they at times were managing the consequences of being over and under-medicated. Participants identified that they were unsure of appropriate MMT dosage levels and adjustments, and that increased communication with the prescribing physician, in addition to more knowledge in this area, would assist them in supporting their clients. Participants identified that receiving education on MMT dosage practices so that they can inform their clients what they can expect would be valuable, and that this information would help when advocating with prescribing physicians on behalf of their clients for dosage adjustments. A statement made by a participant which clarified the connection between MMT dosage and clinical practice was "we need to be educated about MMT dosages so that we can help support our clients in making educated treatment decisions, and have a better understanding of how best to support them".

MMT was also perceived to contribute to clients being able to establish a level of stability and productiveness during and following treatment, which may not have been possible because of their physical and mental state prior to using MMT. Twenty-five percent of participants stated that they perceived clients using MMT as being "motivated clients", and that they are a positive influence on others in the treatment setting. The other 75% of participants had no comments in this regard. An area of concern which was identified was that services available to assist clients using high dosages of MMT to wean down were non-existent and/or unknown to the participants and their clients.

Identification of MMT Clients' Needs



As can be seen in Figure 2, eighty seven percent of participants identified that MMT using clients have additional needs due to their use of MMT, with the remaining 13% not identifying any additional needs for this population above those of the general substance use treatment population. The additional needs identified were: transportation to and from methadone prescribing facilities such as pharmacies; supporting clients to manage the physical effects of methadone; supporting clients to manage the internal pressures and confusion in regards to whether or not their use of MMT negates their "clean time"; supporting clients to managing experiences of stigmatization/marginalization within the recovery community. It was also identified that there is an increased need for intradisciplinary/interdisciplinary collaboration in their care of MMT using clients. The additional needs of clients using MMT in substance use treatment settings were described as being "invisible to the agency" and "swept under the rug". Another participant stated that their organization had become "complacent" and that "clients using MMT are treated the same as others receiving treatment despite their specific needs". This

position was congruent with the responses and perceptions of the participants that acknowledged the additional needs of the MMT using population. It was identified that other special needs groups in the treatment setting, such as those experiencing struggles with spirituality and mental health concerns, were identified and provided with specialized supports, but the specific needs of clients using MMT remained unseen/unaddressed.

Participants' responses indicated that they were often called upon by clients using MMT to support them through situations which were very specific to their use of MMT such as disturbance in sleep patterns, experiences of stigmatization, specific symptomology concerns, withdrawal and overmedicated symptoms to mention a few. The data collected reflected that despite the majority of participants having these experiences with clients using MMT and identifying that there is a need for training and support, these topics were not addressed during clinical supervision, nor have participants received training to address them. Participants' responses also reflected a significant need and desire for specific MMT knowledge in regards to dosage, recommended duration of MMT treatment, and neurochemistry related to MMT. It was the consensus of the participants that these knowledge gaps were contributing to and perpetuating the "invisibility" of the MMT population within treatment settings due to both the participants' unfamiliarity with the needs of clients using MMT and the lack of supports available to them and their clients to address these concerns.

Desire for Training in MMT Specific Practices

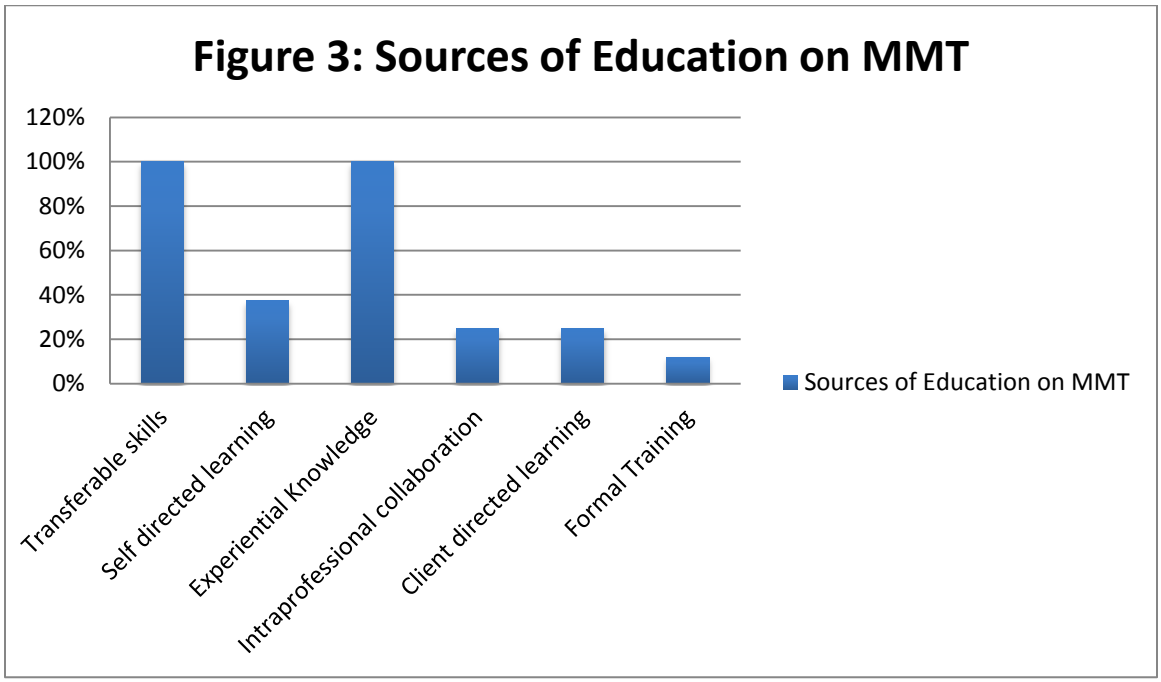


Figure 3 presents the ways in which the participants gain the knowledge used for working with the MMT using population. One-hundred percent of participants' primary sources of knowledge for working with clients using MMT was drawn from experiential knowledge and transferable skills. It was identified that experiential knowledge was gained from working directly with the population, and as one participant stated "learning as you go". Another participant stated that there have been situations in which "clients are more knowledgeable than professionals in regards to MMT and the specific resources available". Transferable skills were identified as being gained through formal university education. Examples of transferable skills identified by participants are client-centered approaches, motivational interviewing, and anti-oppressive practices. These skills were identified by the participants as being very effective for working with clients using MMT.

Twenty-five percent of participants utilized intraprofessional collaboration and client-

directed learning as sources of knowledge. Intraprofessional collaboration refers to participants consulting with prescribing doctors and other medical staff such as nurses and pharmacists in order to learn more about MMT (Wackerhausen, 2009). Client-directed learning is a practice in which participants learn directly from clients what services are available to the MMT using population and what their needs are (Adichie, 2009; Baines, 2011; Kahn, 1991). Thirty-seven-and-a-half percent of participants utilized self-directed learning practices in which they will conduct their own research to learn more about the MMT population and how best to support them. The participants that identified as using this method stated that it is effective, but that it is very difficult to be able to incorporate this approach into their practice due to time constraints and conflicting work responsibilities, and as such is underutilized. Twelve percent of the participants identified that they have received training specific to the provision of services to clients using MMT and that they had received this training as elective choices in their attainment of Undergraduate and Graduate Degrees.

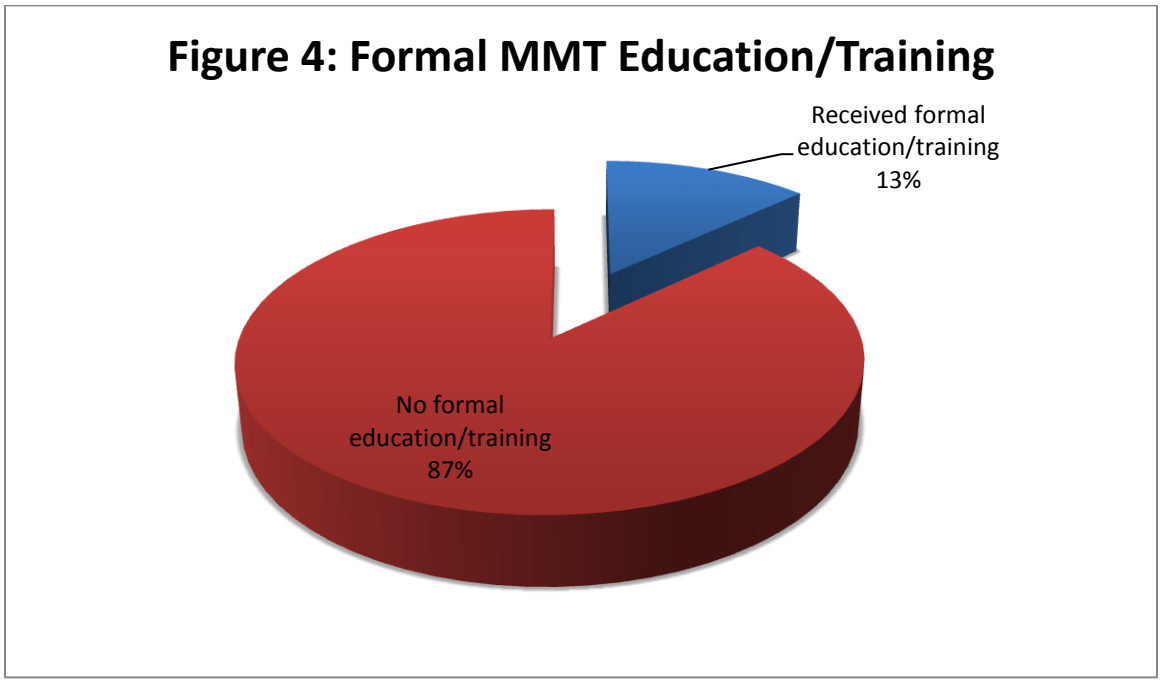


Figure 4 displays that despite the expressed interest and identified need for formal training/education surrounding the support and treatment of MMT using clients by the majority of the participants, 87% of participants identified that they have received little to no training specific to working with the MMT population outside of a general understanding of MMT as a harm reduction practice. The majority of participants stated that they would like to gain more MMT specific knowledge in order to be able to better support their MMT using clients.

One participant stated that staff members "need to be educated about MMT in order to be able to make educated decisions" when working with MMT using clients. Areas of interest identified by participants in regards to receiving education were as follows: the mechanics of MMT, how does it work, what is the optimal duration of treatment, is it a long or short-term approach; education surrounding the prescribing process followed by physicians, how are dosages reviewed, what happens if urine screens are positive for opiates; specific techniques and/or evidence-based practices to work with clients using MMT; education in regards to MMT dosages, detoxification, and tapering in addition to how best to support clients in these areas; and the presentation of longitudinal statistics in regards to the effectiveness of MMT.

When asked how they would like to have access to/receive the above mentioned training/education the participants identified the following: presentations at their agencies from experienced clinical practitioners and/or medical staff such as physicians; externally from their organizations through the Fraser Health Authority in the form of workshops which also provide opportunities to network with other practitioners; and from MMT using clients sharing their success stories and struggles.

Invisibility of Need

Participants observed that clients' using MMT in substance use treatment settings share

many of the same needs as those not using MMT, but simultaneously have additional specific and specialized needs, which as mentioned above are going largely unidentified and unaddressed. Participants identified that it is difficult to meet the needs of clients using MMT in part because of a lack of specific knowledge, but also because of insufficient agency financial and staffing resources. This lack of resources is perceived to manifest itself as insufficient staffing to provide specialized groups, resulting in diversely populated groups in which the needs of clients using MMT are not able to be fully met due to what one participant identified as "facilitators having to deliver very generalized material in order to best meet the needs of all participants in the groups".

Participants identified that groups were at times areas in which myths, misinformation, and ignorance surrounding MMT have led to MMT using clients experiencing stigmatization/marginalization from other group members. Participants that perceived MMT using clients as in need of additional services/supports identified the following in regards to what those additional services/supports are: shared experience groups for MMT using clients; and psychoeducational groups which address MMT specific issues such as side effects, myths, tapering, withdrawal, and sleep disturbance. One participant expressed concern that failure to provide MMT specific supports will lead to higher client drop-out rates, and lower material retention amongst the MMT using population.

Participants in residential treatment settings identified that many administrative staff hold strong abstinence-based values due to their membership in, and adherence to Alcoholics Anonymous programming. It was identified that these beliefs and values are shared openly between administrative staff and residents, and that this has been shown to have a negative stigmatizing/marginalizing effect on clients using MMT. Participants stated that they will

address these issues when they witness them, but identify that providing training to administrative staff could significantly reduce the negative experiences of MMT using clients, and help to dispel commonly held myths and untrue beliefs surrounding MMT. Participants identified that providing education/training to the administrative staff in the following areas would be beneficial: harm reduction; MMT; client-centered practice; anti-oppressive practice; communication and conflict resolution skills.

Participant Desire for Collaborative Practices/Supports

In order to address concerns in regards to the provision of appropriate services to clients using MMT, participants expressed a strong desire for the development and implementation of collaborative practices between methadone prescribing doctors and substance use treatment professionals. The motivation to incorporate collaborative practices was suggested by participants as important so that knowledge and understanding of the changes being made to clients MMT dosages can be shared and clients' needs and behaviors can be addressed and understood. Significant behaviors and experiences which participants believed could be addressed through improved intra-professional practices (Wackerhausen, 2009) were: increased assistance during the transitional period in which MMT using clients are entering the treatment setting; clients nodding in group (a side effect of high doses of methadone in which the client will "nod" off to sleep); the significant sleep pattern disturbances experienced by some MMT using clients which was reported to significantly inhibit a client's ability to participate effectively in treatment; withdrawal symptoms resulting from dosage adjustments; and dispelling client held myths. Participants identified that by increasing intra-professional communication with methadone prescribing physicians and other members of the clients care team, the challenges described above can be understood in context and receive consistent and congruent support so as

to not contribute to further stigmatization and marginalization of clients.

Participants identified that maintaining existing relationships with other organizations such as the Fraser Health Authority, establishing new community connections, and developing working relationships with outside agencies such as community MMT clinics and other substance use treatment settings will be beneficial for not only MMT using clients but also the professionals involved in their care. Through direct contact with other professionals for the purposes of knowledge exchange and support an increased level of consistency of services and care can be achieved. Participants identified that clients would benefit from these collaborative practices by being provided with additional specific supports and familiarity with community resources available throughout not only the duration of their treatment, but also following its completion when clients will return to their families and communities.

The participants also identified a need for more time working with the families of clients using MMT prior to the clients' completion and discharge from treatment. It was identified that once again the lack of financial and educational resources were preventing the provision of sufficient supports and education for clients returning to their families. Participants stated that MMT using clients are leaving substance use treatment settings and entering situations in which their families and/or communities are unprepared in regards to what the needs of the client will be, and where MMT services can be accessed.

Participants expressed a shared desire for knowledge of community supports available for MMT clients remaining on high doses following the completion of their treatment. One participant stated, "We are just not able to work with the families and loved ones of our clients because we don't have time". The premise of this statement that there is a need to provide the families of clients using MMT with education in regards to the aftercare needs of their loved

ones and that if sustainable progress was to be made by clients, a holistic approach to their aftercare including a stronger focus on connecting with and utilizing family and community resources is required, was consistent among the participants.

Implications for Practice, Policy, and Research

This research was a qualitative, cross-sectional exploratory design (Dudley, 2011). The focus of the research was to gather and analyze the perceptions, experiences, observations, insights, and beliefs of professionals working directly with MMT using clients within residential and outpatient substance use treatment organizations. The research was not intended to provide solutions as much as to identify knowledge and service gaps, but important implications for social work practice, policy, and future research have still been identified as a result of the research.

Implications for Practice and Policy

Perpetuate positive perceptions.

The implications for practice and policy which have been realized as a result of this research are tied closely to the themes identified in the existing literature identified above. Harm reduction and abstinence-based practices were identified as making up the context within which MMT services are received by clients. Traditionally/historically, abstinence-based practices have not condoned the use of MMT, viewing it as a replacement/continuation to the initial substance use issue. This research has shown that participants practicing within both harm reduction and abstinence-based models view MMT as a positive practice. This finding is significant to practice and policy in that it can lead to not only the formal inclusion of MMT within all models of treatment, but also its ideological inclusion.

Despite the acceptance of MMT practices by all participants, significant diversity exists in

regards to the definition and understanding of what MMT should look like. Some participants view MMT as a long-term practice, whereas others do not condone long-term use and view MMT as a means of rapid detoxification from opiates. The implementation of policy within agencies that specifically identifies their perspectives and approaches to the role and use of MMT within their programming can assist clients in selecting, and making an educated decision about the organization/agency from which they wish to receive services, and make a decision based on what is the most congruent with their own perspectives. If clients are able to enter into a service delivery environment whose staff are unified in their understanding of, and approaches to MMT, the external challenges experienced by MMT using clients such as stigmatization, marginalization, and myths will be minimized. Clients using MMT will also experience decreased internal/personal challenges due to the fact that they will be in an environment that has a unified and consistent message in regards to the duration, dosages, and trajectory of their MMT use. Whether social workers are providing services directly to MMT using clients, or operating in a brokerage role in which they are referring clients to services, they can work towards perpetuating the positive regard in which MMT is held by professionals. This can be achieved by ensuring that MMT using clients are supported in making educated decisions surrounding their treatment and where they are going to receive it so that client and service provider perspectives on MMT use are congruent.

Increase the visibility of MMT clients' needs.

This research has shown that professionals perceive a need for the unique needs of MMT using clients to be identified and addressed. If organizations/agencies clearly define their individual approaches to MMT use, knowledge and service gaps can be identified. Work can then be undertaken to address both the identified needs of clients and professionals. One of social

work's strengths is its ability to communicate the needs and perspectives of its clients to colleagues, service providers, and other professionals. Increased visibility of the MMT clients' needs can potentially precipitate changes in practice which at the very least will include a raised awareness of the additional unique needs of the MMT using population within the context of the agency/organization. Implications to practice may also take the form of conversations being initiated in staff meetings and clinical supervision sessions about the needs of professionals working with MMT using clients, in addition to what the professionals have identified as specific needs of their MMT using clients. Even a raised awareness amongst professionals and exploratory conversations will have a positive effect on the provision of services to clients as professionals are no longer acting alone in these situations, but are instead accessing the rich and diverse body of knowledge and experience possessed by their colleagues (Wackerhausen, 2009).

As a result of agencies/organizations defining the role of MMT within their programming, staff will be able to be educated as to the needs of their MMT using clients and how best to support them within the context of their organization. As staff become more knowledgeable in the field of MMT they will be able to utilize this knowledge and foster stronger therapeutic relationships with their MMT using clients. These strong therapeutic relationships can in turn positively influence the experiences of clients using MMT through them being able to benefit from their counsellor's MMT knowledge. Strong therapeutic relationships can also lead to the identification of additional needs for professionals and clients which can be shared with the team and addressed through the creation and implementation of facilitated groups designed to specifically meet the needs of the MMT using population, and/or the establishment of peer support groups. The peer support group option may also address the concerns surrounding limited resources available to provide additional services to this population.

Develop training opportunities.

All participants identified that they would like to receive specific training surrounding the process of MMT provision/dosage/duration of use, and its physiological and neurological effects. Interest was also expressed in receiving training on specific practices to working with the MMT population and how best to support them. This theme in the research is congruent with the identification of a dearth of literature pertaining to the provision of MMT services for professions other than doctors and nurses.

Implications of the desire/need for MMT specific training by the participants reinforces the need for intra-professional/collaborative approaches in the provision of effective MMT (Wackerhausen, 2009; CAMH, 2003). In order to address this knowledge and service gap, initiatives can be taken by social workers to develop and provide staff with training opportunities and/or ensure that the needs of professionals providing services to MMT using clients are effectively communicated to management. Opportunities that could be initiated include in-house psycho-education groups and intraprofessional staff presentations by MMT prescribing physicians, pharmacists, nurses, social workers, counsellors, community-based service providers, and MMT consumers. Presentations can take place during staff meetings and/or during times set aside specifically for training. These initiatives can also be incorporated into agency policy as part of the agency's/organization's commitment to continuous professional development which will work towards ensuring that staff attain a specified level of knowledge on MMT and are connected/familiar with MMT specific services in the community. The implementation of this policy will help to ensure the provision of effective services to this population. More formal educational initiatives to meet the identified need for training can also be identified and/or developed so that best practices can be established, and consistency, effectiveness, and efficiency

of service provision can be maintained throughout all organization's/agencies.

The above-mentioned initiatives begin to highlight the importance and need for multidisciplinary collaboration in the provision of effective MMT services. Participants' desire to establish collaborative practices was a theme identified in the research. Establishing and incorporating collaborative/intradisciplinary practices into the provision of services to MMT using clients allows those providing services to draw on the significant combined knowledge and practice experience of colleagues (Wackerhausen, 2009). The establishment of more open relationships between professionals involved with MMT using clients will ensure that clients are able to be effectively and efficiently supported in their use of MMT. Clients can ask for clarification if they are unsure of why certain changes are or are not being made in their treatment and answers can be provided accurately and efficiently. Increased intra-professional collaboration creates an opportunity for professionals to support and encourage their client's autonomy and empowerment through encouragement and the development of effective communication of their needs/concerns to prescribing physicians. Increased levels of intra/inter-professional collaboration also provides professionals the opportunity to advocate on their clients' behalf when required and support them in accurately communicating concerns to the prescribing physician. Advocacy can also involve the workers sharing their professional perspectives and observations of the client's level of functioning and participation while accessing services given their present MMT dosage.

Implications for Future Research

The implications of this research on future research encompass a number of areas. Repeating the research with a more representative sample of not only residential and outpatient facilities/organizations but also other disciplines such as: MMT prescribing physicians,

pharmacists, nurses, social workers, counsellors, probation officers, community-based service providers, MMT consumers, other health authorities, and provinces would allow for a more holistic and representative collection of perspectives. The scope of participants could also be broadened to include staff who not only provide direct services to MMT using clients, but also those who interact with clients using MMT such as reception staff, medication administers, and family members.

Individuals occupying administrative and reception roles were identified by many of the participants as holding the most marginalizing and rigid beliefs in regards to the ineffectiveness of MMT use. A valuable area for future research would be to collect and analyze the perceptions, experiences, observations, insights, and beliefs of this population, and their effect on the MMT using population. This research could then be used to identify ways in which to provide education and support to this population in order to increase their skill level in interacting with clients utilizing diverse treatment modalities, and decrease the experiences of marginalization for MMT and other harm reduction using clients.

Future research can be conducted to collect the significant practice-based knowledge and experiences of those working with the MMT using population and combine it into a format that can be reviewed/analyzed and structured into a format that can be disseminated to all professionals working with this population. Through the analysis of this research the researcher was able to identify that within the context of group counselling the specific needs and topics of concern for clients using MMT could be observed. This information could also be collected to identify the needs of clients and those providing services. This information can be used to better understand the practices currently being used, and the need for training, in addition to contributing towards increasing the level of quality and consistency of service delivery for

clients using MMT within agencies and throughout the health authority.

Another theme identified in the research which could benefit from future research is the identification of a lack of and/or unawareness of community supports for MMT using clients and their families. The identification of this gap in service for MMT using clients and their families following treatment speaks to the importance of not only addressing the needs of this population on the micro level, but also mezzo and macro levels (Pauly, 2008; Smye et al, 2011). The implications of these findings on future research are that research can be conducted to develop initiatives to familiarize professionals with the existing services/resources available to this population, and/or to identify the lack of specific resources for this population and work towards identifying and addressing this need for services. Social workers can participate in this process by utilizing their community building and networking skills to connect service providers and facilitate intra-professional collaboration between MMT service providers.

One participant asked "Why does opiate dependence and MMT receive so much attention when there are many other substance dependencies which are being treated in residential and outpatient settings?" This question identifies yet another area in which future research will prove to be of value, identifying the present level of specific knowledge, supports, and resources available for the treatment of other substances and whether or not professionals require specific support, education, and/or training to work in these areas.

Limitations of the Study

Several limitations of the research must be taken into account. The themes identified are drawn from a small sample size. This is a significant limitation because the sample is not representative, nor are its findings generalizable. Due to the small sample size, it is also possible that the themes identified may be overgeneralizations. The participants were not all anonymous

in that some participant's names were provided to the researcher by the agencies' Clinical Supervisors, bringing into question whether or not participation was voluntary, and whether or not participants felt safe expressing their true perspectives (Dudley, 2011).

Several agencies/organizations that were contacted by the researcher to participate in the research decided not to participate for a mixture of reasons including but not limited to; not being able to see the relevance of the research to their organization; being unable to commit to the process due to staffing and time shortages; an unwillingness to participate; and refusal to acknowledge the researcher's attempts at contact. There are many approaches adopted by substance use treatment organizations which were not represented in this sample. Some organizations/service providers adhere to paternalistic and strictly abstinence-based practices whereas others adopt more liberal harm reduction practices, with many other variations occurring between the two standpoints. This research was not able to attain a sample that had adequate representation from these varied approaches, and it is unfortunate that these agencies/organizations valuable perceptions, experiences, observations, insights, and beliefs were not represented in the research.

In addition to organizations/agencies adopting diverse practice models, there is also divergence in the level of education attained by staff working with the MMT using population. This diversity may contribute to the amount of "transferable" skills which are available to be drawn from by professionals when working with their clients who are using MMT. Given that analysis of the research identified that transferable skills were a major source of knowledge utilized by participants when determining how best to work with clients, diversity in the level of education achieved by practitioners can affect the level of education and support required by those professionals in working effectively with the MMT using population, and ultimately the

quality of services received by clients using MMT.

Summary

This research was designed to gather and analyze the perceptions of professionals working within residential and outpatient substance use treatment organizations, surrounding the effectiveness of MMT within their substance use treatment settings. A review of the literature pertaining to the research topic led to the identification that therapeutic relationships contribute towards the implementation of harm reduction techniques, and that the implementation of harm reduction practices has positive effects on positive client outcomes, skill retention, and decreased experiences of stigma and marginalization. The literature review also led to the identification of knowledge and service gaps in regards to what training and supports are available to professionals working with the MMT using population, and what are considered to be best practices.

The analysis of the qualitative research gathered through one-on-one face-to-face interviews following a cross-sectional exploratory design (Dudley, 2011) and following a general interview guide approach led to the identification of several themes. The themes identified were: that MMT is positively perceived by professionals working with MMT using clients; the specific needs of the MMT using population are invisible to the agencies/organizations providing them with services; that there is a desire amongst professionals for training specific to working with this population; and that the development of collaborative practices is also desired.

An absence of specific knowledge and training existing/being made available to professionals working with clients using MMT in substance use treatment settings was identified. The analysis of the research data was able to show that the majority of participants believe that clients using MMT have specific needs above and beyond those of their substance

use treatment cohort. It was also identified within the research that professionals are largely working individually to address the specific needs of clients using MMT, and that there does not presently appear to be a consistent service delivery model/best practice in place.

Participants were identified to be largely utilizing their experiential knowledge and transferrable skills as primary sources of information to address the specific needs of clients using MMT. Although these individual approaches to service delivery can be immediately helpful to clients, it is doing little to address the larger systemic challenges of providing appropriate and consistent services to clients using MMT and continues to hide the needs of this population from other groups and professionals able to advocate and work towards practice, policy, and systematic change.

Implications of the research are that the findings can be used to contribute towards developing and/or implementing best practices by influencing existing training and support structures to better meet the needs of professionals working with the MMT using population and their clients.

The perceptions of professionals from very diverse approaches to substance use treatment as MMT being a positive treatment option is promising in that it is moving away from a binary understanding of positive treatment outcomes.

Conclusion

The literature review for this paper was used to identify the existing context in which MMT using clients are receiving services. It was identified that regardless of whether a harm reduction or abstinence-based approach was used, that therapeutic relationships are central to success. Despite the significant positive effects of these relationships with MMT using clients, it is not possible to establish them if clients do not access services. Experiences of stigma and

marginalization when trying to access services prevents many clients from entering services, and it has also been shown that these factors contribute to increased dropout rates of those who do access services. Despite there being mention of the importance of holistic approaches to service delivery for MMT using clients, there was a dearth of literature identifying best practices for professionals other than physicians and nurses providing services to this population. It was identified in the literature that physicians' decisions in regards to MMT prescription are influenced by non-medial and subjective factors. If these factors are shown to effect service provision from physicians, it stands to reason that a deeper understanding of the perceptions of other professionals providing services to MMT using clients is required to ensure that oppressive practices are challenged.

This paper has presented the perceptions, experiences, observations, insights, and beliefs of the professionals delivering services to clients using MMT. By identifying and understanding these factors, gaps in knowledge and services have been acknowledged and a need for additional research to develop and implement the required training and supports needed to work effectively and efficiently with this population have been identified. Analysis of the research has contributed to a deeper level of understanding in regards to the needs of those providing services to MMT using clients. As such, the need to work towards better addressing the needs of clients using MMT and those providing them with services has also been identified. Harm reduction services are intended to serve those in need, so ensuring that professionals have a sufficient understanding of the population they are working with, and are able to meet the specific needs of MMT using clients is essential (Baines, 2011; CAMH, 2003; Kerr et al, 2006; Osborn & Small, 2005; Pauly, 2008; Smye, Browne, Varcoe & Josewski, 2011). This is an area in which social workers can be instrumental in bridging this knowledge/service gap by practicing/promoting anti-oppressive and

client-centred practices.

The findings of this research indicate that the overall perception of participants in regards to MMT use is positive. This finding has significance because of the historically strongly held and often dichotomized perceptions of harm reduction practices between professionals adhering to abstinence and harm reduction models of service delivery. Analysis of the research identified that perceptions of how best to utilize MMT are still a very divided topic, and that this is contributing to incongruence in service delivery to the MMT using population and perpetuating erroneous understandings, myths, and stigmatizing and marginalizing experiences for this population. Further research and analysis of the shared beliefs between professionals in addition to areas of incongruence will provide the opportunity to develop and implement best practices and policy which are holistic and consider the needs of all involved rather than regarding service providers as a homogenous group.

The acknowledgement of the invisibility of the specific needs of the MMT using population, and subsequently the recognition that those providing services to this population do not have access to training and support in this area is significant in that the needs of the professionals and clients are ultimately no longer invisible. Further analysis of the research identified that participants regard inter/intradisciplinary collaboration and formal training opportunities as a way of addressing this gap in knowledge and training. This suggested approach will foster collaborative relationships in which professionals will gain access to a shared body of knowledge and practice experience which is inaccessible when working alone (Wackerhausen, 2009). Combining client-centered practices with the above mentioned initiatives can positively contribute towards not only meeting the micro level needs of the MMT using population but also the mezzo and macro levels of the issue by influencing policy

implementation which will lead to more consistent service delivery within and between agencies/organizations and the health authority.

The use of MMT has been shown to increase access to services, improve positive client outcomes, and increase knowledge retention. If the common ground of positive regard to MMT use can be solidified, then perhaps a shared definition of success and positive outcomes can be understood not as a binary between abstinence and using, but instead from a more holistic and fluid perspective. This new definition of success can be defined by the reduction of negative consequences experienced as the result of substance use leading to de-marginalization and engagement in programs that focus on increasing quality of life, social functioning, happiness, and autonomy through incremental change. If this new measure of success can be implemented then perhaps the statistics would be more impressive in the long term (Gowen et al, 2012; Gu et al, 2012; Kerr et al, 2006; Lee & Zerai, 2010; Sellman, 2009).

References

Adichie, C. (2009), The dangers of a single story Tedtalks [video file]. Retrieved from: http://www.youtube.com/watch?v=D9Ihs241zeg

Baines, D. (Ed.). (2011). *Doing anti-oppressive practice social justice social work* (2nd ed.). Halifax, NS & Winnipeg, MB: Fernwood Publishing.

Ball, A. L. (2007). HIV, injecting drug use and harm reduction: A public health response. *Society for the Study of Addiction, 102*, 684-690. doi: 10.1111/j.1360-0443.2007.01761.x

Bennett, C. (2011). Methadone maintenance treatment: Disciplining the 'addict.'. *Health & History: Journal of the Australian & New Zealand Society for the History of Medicine, 13*(2), 130-157. Retrieved from: http://search.ebscohost.com.proxy.ufv.ca:2048/login.aspx?direct=true&db=30h&AN=78176381&site=eds-live

Blume, A. W., & Lovat, L. (2010). Empowering the disempowered: Harm reduction with Racial/Ethnic minority clients. *Journal of Clinical Psychology: In Session,* 66(2), 189-200. doi: 10.1002/jclp.20668

Carlin, T. (2005). An exploration of prisoners' and prison staff's perceptions of the methadone maintenance programme in Mount Joy male prison, Dublin, republic of Ireland. *Drugs: Education, Prevention & Policy, 12*(5), 405-416. Retrieved from http://search.ebscohost.com.proxy.ufv.ca:2048/login.aspx?direct=true&db=s3h&AN=18685699&site=eds-live

Centre for Addiction and Mental Health. (CAMH). (2003). *Methadone Maintenance: A Counsellor's Guide*. Toronto, ON: Centre for Addiction and Mental Health.

Centre for Addiction and Mental Health (CAMH). (2009). Mehtadone Maintenance Therapy: Information for Clients. Retrieved from: https://knowledgex.camh.net/amhspecialists/resources_families/Pages/methadone_therapy.aspx

Centre for Addiction and Mental Health (CAMH). (2009). Overview of Mehtadone Maintenance Treatment. Retrieved from: https://knowledgex.camh.net/amhspecialists/specialized_treatment/methadone_maintenance/Pages/default.aspx

Centre for Addiction and Mental Health (CAMH). (2011). Methadone maintenance treatment program standards and clinical guidelines. Retrieved from: http://www.camh.ca/en/education/Documents/www.cpso.on.ca/uploadedFiles/policies/guidelines/methadone/Meth%20Guidelines%20_Oct07.pdf

Chan, A. S. (2013). In Dr. Adrienne S. C. (Ed.), *Weekly lecture*. University of the Fraser Valley

Chen, T., Masson, C. L., Sorensen, J. L., & Greenberg, B. (2009). Residential treatment modifications: Adjunctive services to accommodate clients on methadone. American Journal of Drug & Alcohol Abuse, 35(2), 91-94. Retrieved from http://search.ebscohost.com.proxy.ufv.ca:2048/login.aspx?direct=true&db=s3h&AN=37185107&site=eds-live

City of Abbotsford. (2013). Harm Reduction Forums, Abbotsford. Congress, E. P. (2008). Cultural and ethical issues in working with culturally diverse patients and their families. *Social Work in Health Care, 39*(3-4), 249-262. doi: 10.1300/j010v39n03_03

Cooper, M. G., & Lesser, J. G. (2011). *Clinical social work practice an integrated approach* (4th ed.). Boston: Pearson.

Congress, E. P. (2008). Cultural and ethical issues in working with culturally diverse patients and their families. *Social Work in Health Care, 39*(3-4), 249-262. doi: 10.1300/j010v39n03_03

Dalton, B. (2005). Teaching cultural assessment. *Journal of Teaching in Social Work, 25*(3/4), 45-61. doi: 10.1300/j067v25n03_04

Dudley, J. R. (2011). *Research methods for social work: Being producers and consumers of research.*(2nd ed.). Boston: Pearson.

Fraser Health. (2011). Accreditation: Committed to quality and safety. *Fraser health: Better. health. Best in health care.* Retrieved April 20, 2013, from http://www.fraserhealth.ca/about_us/accountability/accreditation/

Go, F., Dykeman, M., Santos, J., & Muxlow, J. (2011). Supporting clients on methadone maintenance treatment: A systematic review of nurse's role. *Journal of Psychiatric & Mental Health Nursing, 18*(1), 17-27. doi: 10.1111/j.1365-2850.2010.01628.x

Goheen, M. (2013). Methadone Maintenance Treatment: A survey of consumer, treatment cohort and substance use service professional perspectives. Unpublished survey, Fraser Health Mental Health & Substance use Services, Fraser Health, Maple Ridge, Canada.

Gowan, T., Whetstone, S., & Andic, T. (2012). Addiction, agency, and the politics of self-control: Doing harm reduction in a heroin users' group. *Social Science & Medicine,* 74, 1251-1260. doi: 10.1016/j.socscimed.2011.11.045

Gu, J., Xu, H., Lau, J.T.F., Hao, Y., Zong, Y., Fan, L., Zhao, Y., Hao, C & Ling, W. (2012) Misconceptions predict dropout and poor adherence prospectively among newly admitted first-time methadone maintenance treatment clients in Guangzhou, China. *Addiction Research Report*. doi: 10.1111/j.1360-0443.2012.03859.x

Grinnell, R.M., Gabor, P. A., & Unrau, Y.A. (2010). *Program evaluation for social workers: Foundations of evidence-based programs.*(5th ed.). New York, NY: Oxford.

Heron, B. (2005). Reflective practice: International and multidisciplinary perspectives self-reflection in critical social work practice: Subjectivity and the possibilities of resistance. *Reflective Practice*, 6(3), 341-351. doi: 10.1080/14623940500220095

Health Canada. (2008). Best Practices: Methadone Maintenance Treatment. In Health Canada. Retrieved Februry 11, 2014, from http://www.hc-sc.gc.ca/hc-ps/pubs/adp-apd/methadone-bp-mp/index-eng.php.

Kahn, M. (1991). *Between therapist and client: The new relationship* (Revised ed.). New York: Henry Holt And Company.

Karger, H. J., & Hernandez, M. T. (2004). The decline of the public intellectual in social work. *Journal of Sociology and Social Welfare*, 31(3), 51-68.

Kelly, S. M., O'Grady, K. E., Brown, B. S., Mitchell, S. G., & Schwartz, R. P. (2010). The role of patient satisfaction in methadone treatment. *American Journal of Drug & Alcohol Abuse, 36*(3), 150-154. Retrieved from. http://search.ebscohost.com.proxy.ufv.ca:2048/login.aspx?direct=true&db=s3h&AN=50472501&site=eds-live

Kerr, T., Small, W., Peeace, W., Douglas, D., Pierre, A., & Wood, E. (2006). Harm reduction by a "user-run" organization: A case study of the vancouver area network of drug users (VANDU). *The International Journal of Drug Policy*, 17, 61-69. doi:10.1016/jdrugpo.2006.01.003

Kleinig, J. (2008). Harm reduction: Ethics. The ethics of harm reduction. Substance use and Misuse, 43, 1-16. doi:10.1080/10826080701690680

Lee, H. S., & Zerai, A. (2010). Harm reduction "everyone deserves services no matter what": Defining success in harm-reduction-based substance user treatment. *Substance use and Misuse*. 45, 2411-2427. doi: 10.3109/10826081003712060

Little. J, , & Franskoviak. P. (2010). So glad you came! harm reduction therapy in community settings. Journal of Climical Psychology: In Session, 66(2), 175-188. doi: 10.1002/jclp.20673 Osborn, B., & Small, W. (2006). "Speaking truth power": The role of drug users in influencing municipal drug policy. *The International Journal of Drug Policy*, 17, 70-72. doi:10.1016/j.drugpo.2005.09.001

Luce.J., Strike. C. (2011). A Cross-Canada Scan of Methadone Maintenance Treatment Policy Developments: A Report Prepared for the Canadian Executive Council on Addictions. Retrieved from: http://www.ceca-cect.ca/pdf/CECA%20MMT%20Policy%20Scan%20April%202011.pdf

Maremmani, I., Pacini, M., & Pani, P. (2011). Basics on Addiction: a training package for medical practitioners or psychiatrists who treat opioid dependence. Heroin Addiction And Related Clinical Problems, 13(2), 5-40.

Martin, T., Lewis, T., Josiah-Martin, J.A, & Sinnot, T. (2010). Client Family-Member Participation Is Associated with Improved Residential Treatment Program Completion at an International Drug and Alcohol Treatment Center. *Journal of Groups in Addiction & Recovery*.5, 34-44. doi: 10.1080/155603509035439331

McNamee, S. & Gergen, K.J. (Ed.). (2010). *Therapy as social construction*. Thousand Oaks, CA: SAGE Publications Ltd.

Mitchel, T.B., Dyer, K., & Peay, E. (2006). Patient and Physician Characteristics in Relation to Clinical Decision Making in Methadone Maintenance Treatment. *Substance Use and Misuse*, 41, 393-404. doi: 10.1080/10826080500409043

Osborn, B., & Small, W. (2006). "Speaking truth power": The role of drug users in influencing municipal drug policy. *The International Journal of Drug Policy*, 17, 70-72. doi:10.1016/j.drugpo.2005.09.001

Parkes, T., & Reist, D. (2010) British Columbia Methadone Maintenance Treatment Program A Qualitative Systems Review – Summary Report. Retrieved:

http://www.ankors.bc.ca/ccc/MMT%20in%20BC%20Qual%20Systems%20Review%20Report%20Summary.pdf

Pauly, B. (2008). Harm reduction through a social justice lens. *The International Journal of Drug Policy*, 19, 4-10. doi:10.1016/j.drugpo.2007.11.005

Philbin, M. M., & Zhang, F. (2010). Exploring stakeholder perceptions of facilitators and barriers to accessing methadone maintenance clinics in Yunnan province, China. *AIDS Care, 22*(5), 623-629. doi: 10.1080/09540120903311490

Rollnick, S., Miller, W. R., & Butler, C. C. (2009). *Motivational interviewing in health care: Helping patients change behavior*. Boston: Pearson.

Sellman, D. (2009). The 10 most important things known about addiction. *Society for the Study of Addiction*, 105, 6-13. doi: 10.1111/j.1360-0443.2009.02673.x

Smye, J., Browne, A. J., Varcoe, C., & and Josewski, V. (2011). Harm reduction, methadone maintenance treatment and the root causes of health and social inequities: An intersectional lens in the Canadian context. *Harm Reduction Journal*, 8(17), 1-12. doi:10.1186/1477-7517-8-17

Strang, J., Hunt, C., Gerada, C., & Marsden, J. (2007). What difference does training make? A randomized trial with waiting-list control of general practitioners seeking advanced training in drug misuse. Addiction, 102(10), 1637-1647. doi: 10.1111/j.1360-0443.2007.01929.x

Trafton, A. J., Minkel, J., Humphreys, K. (2006). Determining Effective Methadone Dosages for Individual Opioid-Dependent Patients. PLOS Medicine 3(3), e80. doi:

10.1371/journal.pmed 0030080

Wackerhausen, S. (2009). Collaboration, professional identity and reflection across boundaries, Journal of interprofessional *Care*, *23*(5), 455-473. doi: 10.1080/13561820902921720

Appendix A

Certificate of Human Research Ethics Board Approval - Amendment

Contact Person	Department	Protocol
Justun Miller	Social Work	555
Co-investigators Leah Douglas; Adrienne Chan		
Title of Project Professionals' perspectives regarding the effectiveness of Methadone Maintenance Treatment in residential treatment centers.		
Sponsoring/Funding Agency None		
Institution(s) where research will be carried out University Of The Fraser Valley		

Review Date:	Amendment Date:	Original Approval Date:	Approval Term:
10-Apr-13	09-Apr-13	05-Mar-13	5-Mar-13 - 4-Mar-14

Certification:

The protocol describing the above-named project has been reviewed by the UFV Human Research Ethics Board and the procedures were found to be in compliance with accepted guidelines for ethical research.

Kathy Keiver, Chair, Human Research Ethics Board

NOTE: This Certificate of Approval is valid for the above noted term, provided there is no change in the procedures or criteria given.

If the project will go beyond the approval term noted above, an extension of approval must be requested.

33844 King Rd., Abbotsford, BC V2S 7M8 • Tel: 604-504-7441 • Fax: 604-855-7614 • Toll-free (in Canada): 1-888-504-7441 • **www.ufv.ca**

ABBOTSFORD • CHILLIWACK • MISSION • HOPE • AGASSIZ • CHANDIGARH

Appendix B

From: Justun.Miller@student.ufv.ca
Subject: Social Work Research Participation Request

February 24, 2013

Dear Colleague:

Re: Invitation to participate in a research project

My name is Justun Miller and I am a Master of Social Work student at the University of the Fraser Valley (UFV). I am currently working as an Adult Drug and Alcohol Counselor at Alouette Addictions Services in Maple Ridge. I am conducting research as a part of my graduate Master of Social Work (MSW) project at UFV.

The ethics of this project have been reviewed and approved by the UFV Human Research Ethics Board.

The research includes the following objectives:

1. To explore the perceptions of professionals in regards to the effectiveness of Methadone Maintenance Treatment (MMT) in substance use treatment.
2. To determine if a need exists for training for professionals around working with clients on MMT.
3. To determine if a need exists for support for professionals around working with clients on MMT.

I am requesting your participation in the project because I believe that as professionals working directly with those using MMT you possess valuable experience and knowledge which can contribute to the potential development and provision of supports and training.

If you agree to participate in this research, you will participate in a one hour interview. The questions are intended for you to give the researcher your views and do not require the disclosure of any confidential or sensitive information. The interviews will be audio-taped, with your consent. If you do not agree to be audio-taped, notes will be taken.

The tapes will only be reviewed by the researcher and his supervisors Dr. Leah Douglas (leah.douglas@ufv.ca; 604-504-7441, Local 4292), and Dr. Adrienne Chan (Adrienne.chan@ufv.ca; 604-557-4074). The purpose of the tapes is to review ideas, themes, and data generated in the interview. To ensure confidentiality and anonymity, no names, agencies or identifying information of participants will be used in the development of the summary data. However, the researcher will provide summary information (e.g. identify professionals' positions, education levels). A summary report of the research will be available upon your request.

In preparing the findings of the research, the researcher will prepare a summary report. A research paper will be the final product of this research activity. It will be submitted for approval as a graduation requirement for the MSW program at UFV. The research may prove to be of interest to Fraser Health and as such, the findings could be disseminated to them as a publication or presentation.

If you are interested in participating in the research project, please contact the researcher at your earliest convenience by phone and/or e-mail: Justun.Miller@student.ufv.ca ; 778-238-0787.

Thank you for your consideration.

Sincerely,

Justun Miller BSW, MSW Candidate, RSW

Appendix C

School of Social Work and Human Services
University of the Fraser Valley
33844 King Road
Abbotsford BC V2S 7M8
604 504 7441

February 21, 2013

Letter of Informed Consent

What are the perceptions of professionals who work with methadone maintenance treatment (MMT) clients - with regard to whether or not MMT use is effective in substance use treatment?

Researcher: Justun G. Miller. (Justun.Miller@student.ufv.ca ; 778-238-0787)
Supervisor: Dr. Leah Douglas (leah.douglas@ufv.ca; 604-504-7441, Local 4292)
Instructor: Dr. Adrienne Chan (Adrienne.chan@ufv.ca; 604-557-4074)

Description of the Project:

My name is Justun Miller and I am a Master of Social Work student at the University of the Fraser Valley (UFV), and I am currently working as an Adult Drug and Alcohol Counselor at Alouette Addictions Services in Maple Ridge. Together with the School of Social Work And Human Services at UFV, I am conducting an exploratory research project to identify the perceptions of professionals working with clients using methadone maintenance treatment (MMT) and its effectiveness.

The ethics of this project have been reviewed and approved by the UFV Human Research Ethics Board.

The objectives of this research are to identify professionals' perspectives regarding the effectiveness of MMT in substance use treatment. This includes understanding the level of training received by professionals in working with MMT clients, perceptions of strengths and limitations of MMT in substance use treatment, and perceptions of how to address limitations.

Participation in the Project:

If you agree to participate in this research, you will participate in a one hour interview. These questions are intended for you to give the researcher your views and do not require the disclosure of any confidential or sensitive information. The interviews will be audio-taped, with your consent. If you do not agree to be audio-taped, notes will be taken.

The tapes will only be reviewed by the researcher and his supervisors. The purpose of the tapes is to review ideas, themes, and data generated in the interview. To ensure confidentiality and anonymity, no names, agencies or identifying information of participants will be used in the development of the summary data.

All raw data (tapes and notes) will be kept in a secure locked drawer in the office of the researcher at Alouette Addictions Services. All raw data (tapes and notes) will be erased and destroyed on or by March 1, 2014. Participation is strictly voluntary and you may withdraw yourself and/or your data at any time. The data collected prior to withdrawal will remain part of the research project, with your permission. There is no monetary compensation for participation.

As a participant, you will be given the opportunity to review the summary of what you said, and to clarify and revise your input. There are no anticipated risks to your participation in this interview. Confidentiality will be broken if the researcher believes that disclosure is essential to the prevention of harm to self or others. The possible benefits for participating in the research are that future policy development and employee training opportunities may be influenced.

In preparing the findings of the research, the researcher will prepare a summary report. A research paper will be the final product of this research activity. It will be submitted for approval as a graduation requirement for the MSW program at UFV. The research may prove to be of interest to Fraser Health and as such, the findings could be disseminated to them as a publication or presentation.

No names or identifying information of the participants or organizations will be used in the report. This will protect your anonymity. However, the researcher will provide summary information (e.g. identify professionals' positions, education levels). A summary report of the research will be available upon your request.

Any questions regarding the research may be discussed prior to the commencement of the interview. Any questions about the project or any follow up may be directed to the researcher:

Justun G. Miller BSW, MSW (Can.), RSW, (Justun.Miller@student.ufv.ca ; 778-238-0787); and/ or supervisor: Dr. Leah Douglas (leah.douglas@ufv.ca; 604-504-7441, Local 4292).

Thank you for agreeing to participate in this research.

Consent

By signing below I agree to participate in this study, titled Perceptions of methadone maintenance treatment.

I have read the information presented in the letter of informed consent being conducted by Justun Miller and faculty at the University of the Fraser Valley. I have had the opportunity to ask questions about my involvement in this study, and to receive any additional details.

I understand that I have the right to withdraw from the study at any time and that confidentiality and/or anonymity of all results will be preserved. Any concerns about the research may be directed to Mr Brad Whittaker, Director, Research Services & Industry Liaison at UFV (604-557-4044; Brad.Whittaker@ufv.ca).

I agree to have the interview audio-taped (Please check Yes or No):

Yes _____ NO_____

Name (please print):_____

Signature:_____

Date:_____

Witness signature:_____

Once signed, a copy of this consent form will be provided to you

Appendix D

Interview Guide

Research Question:

What are the perceptions of professionals who work with methadone maintenance treatment (MMT) clients with regards to whether or not MMT use is effective in substance use treatment?

Objectives:

1. To explore the perceptions of professionals in regards to the effectiveness of MMT in substance use treatment.
2. To determine if a need exists in regards to training for professionals in substance use treatment around working with clients using MMT.
3. To determine if a need exists in regards to support for professionals in substance use treatment around working with clients using MMT.

Background Information:

1. What is your gender?
2. What is your age?
3. What is your ethnicity?
4. What level of education do you currently hold? Bachelor of Social Work, Substance Use Diploma…?
5. What year did you achieve your qualifications?
6. How long have you been working in the addictions field?
7. What is your classification at the treatment center? (Counselor, Group Facilitator…)
8. What model of recovery does this treatment center adhere to: 12 steps, wellness wheel…?

Preamble:

A working definition of professional is:

A person employed by an organization that has direct therapeutic contact with clients using methadone maintenance treatment (MMT), in one-on-one and/or group settings.

A working definition of effective is:

Clients obtaining the intended or expected goals established upon entering into the substance use treatment.

Interview questions:

1. Can you tell me about your work with MMT clients?
2. What training, if any, have you received to work with people who use MMT?
3. Where did you receive your training?
4. What would you need in order to increase your knowledge/proficiency in working with people who use MMT?

5. What are the advantages (if you think that there are any) of having people who use MMT accessing services at this organization? Could you share a situation/story that illustrates your point?
6. What are the limitations and challenges (if you think that there are any) of having people who use MMT accessing services at this organization? Could you share a situation/story that illustrates your point?
7. What supports are in place for you as a worker working with this population?
8. What barriers exist for you as a worker in regards to working with this population?
9. In your experience, are there noticeable differences in the successful completion rates of treatment between people who use MMT and those who do not in this organization? Can you speculate on what accounts for the differences in completion rates?
10. What are your perceptions about the effectiveness of MMT being used in this organization?
11. Are your perceptions consistent with other professionals at this organization? Please explain.
12. What approach do you take when your perceptions are different from other professionals at this organization?
13. Do you believe that it is effective to have people who use MMT in this organization? Please explain what effective means to you, and how you measure it.
14. Any other comments?